THE PHYSICIAN'S DUTY TO DISCLOSE RISKS OF TREATMENT

MARVIN LIEBERMAN, Ph.D., LL.B.

Executive Secretary
Committee on Medicine in Society
The New York Academy of Medicine
Member, New York Bar
New York, N. Y.

AMONG the most important and complex legal and ethical responsibilities assumed by the physician before embarking on a course of therapy is the duty to disclose the risks that are incidental to medical treatment and also the alternative treatments that may be available to the patient. This entire matter is sometimes referred to broadly as the problem of obtaining "informed consent." A recent decision of the United States Court of Appeals for the District of Columbia by Circuit Judge Spottswood W. Robinson III in *Canterbury* v. *Spence*[1] reviews the problem so comprehensively that it is a good starting-point for discussion.

A young man who had pain in his back underwent an operation "without being informed of a risk of paralysis incidental thereto."[2] The patient had undergone laminectomy of the fourth thoracic vertebra to correct suspected rupture of an intervertebral disc. A day after the procedure the patient fell from his bed. The lower part of his body became paralyzed. Despite subsequent operations he never recovered from paralysis or from urinary incontinence.

Dr. Spence, the physician who had performed the operation, was called to testify as an adverse witness on the issue of the cause of the disability. He testified that paralysis can occur, even without trauma, in "somewhere in the nature of one percent" of laminectomies, a risk he described as "a very slight possibility."[3] He conceded that he did not communicate that risk to the patient because he deemed it poor medical practice to deter patients from undergoing needed surgical operations and because he was concerned about adverse psychological reactions which might prevent a successful outcome.

The defendant hospital and physician moved for a directed verdict

immediately after the plaintiff had presented his case. The trial judge granted the requested ruling. He explained that no evidence had been presented which indicated any negligence in the diagnosis or procedure or that the treatment was responsible for the plaintiff's disability; although there was evidence of postoperative negligence, no expert proof as to its cause had been submitted.

The Court of Appeals reversed that ruling, finding that the failure to disclose a risk of paralysis "made out a prima facie case of violation of the physician's duty to disclose which Dr. Spence's explanation did not negate as a matter of law."[4] As to whether negligence was causally related to the plaintiff's conduct, the appellate court found other evidence to justify permitting the case to go to the jury.

An examination of the issues discussed in the opinion which dealt with the physician's duty to disclose risks and alternatives of treatment might best be handled in the form of questions and answers:

1) What is the general basis of the physician's duty to disclose? Courts often cite Judge* Benjamin N. Cardozo's statement: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[5] The patient must consent to a particular procedure, but a general consent to a procedure without a disclosure of the risks involved would, where the patient has little or no understanding of medicine, undermine the patient's "right to determine what shall be done with his own body." Courts still differ as to whether failure to disclose collateral risks where damage has resulted from an operation otherwise adequately performed is a battery (an unauthorized touching of another person's body) or negligence (carelessness or failure to conduct oneself reasonably in the conduct of a duty). The consequences of treating the matter as battery or as negligence relate to the necessity of expert witnesses, length of time of the applicable statute of limitations, and amount of damages recoverable. In the Canterbury case the court applied the language of negligence.

In a recent New York case—*Fogal* v. *Genesee Hosp.*[6]—the New York court, although it approved the discussion of the duty to disclose in the Canterbury case, stated that the matter of informed consent is "not based on any theory of negligence but is an offshoot of the law of assault and battery. Any non-consensual [without permission] touching of a patient's body, absent an emergency, is a battery and the theory is

*Later, Justice.

that an uninformed consent to surgery obtained from a patient lacking knowledge of the dangers inherent in the procedure is no consent at all."[7] Some commentators suggest that the battery theory be employed when the patient consents to one procedure but actually undergoes another, whereas the theory of negligence should be applied where the patient undergoes the operation he expects but suffers injury from a risk that had not been disclosed to him.[8]

2) What standards govern the physician's duty to disclose? Most jurisdictions in the United States make the duty to disclose dependent on the custom of physicians in the community, but the Canterbury case and the Fogal case in New York show a shift away from this general rule. In the Canterbury case the court argued that failure of a physician to comply with a professional custom may result in liability but that the patient's case is not dependent on medical custom. The court was skeptical about testimony that purports to describe a custom but may actually be a personal opinion as to what a physician might do under certain circumstances ". . . [T]o bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone." The patient's right of self-decision "demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves."[9]

3) What is the scope or extent of the disclosure requirement? "Full" disclosure of any risk, no matter how small or remote, as a standard is rejected as "prohibitive and unrealistic." The cases requiring full disclosure are found to call for something less than total disclosure—which leaves the answer still open as to how much is "full." The reasoning of cases calling for a standard measured by "good medical practice" or by "medical custom" is also rejected (see No. 2 above). The information that a reasonable man in the patient's position needs to make a decision is what must be disclosed according to this case. The court agreed with Professor Jon R. Waltz that "[a] risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."[10]

The court points out that for some dangers, such as that of infection, which a person of "average sophistication should know," there is no requirement to disclose. But where a potential disability outweighs

the potential benefit of treatment, a small chance of death and disablement may outweigh dramatically the benefit of the treatment, and discussion with the patient is required.

One assumes that the widest possible dessemination of risks of treatment to patients through the communications media by way of educational programs and articles would lighten some of the burden of disclosure that now rests upon the physician.

4) What exceptions are there to the general rule of disclosure? There are two exceptions which the court describes under the physician's privilege not to disclose. The first is where the patient is unconscious and thus unable to consent and where the harm from no treatment would be immediate. The physician must still make an effort to get in touch with the patient's family in this case. The second situation occurs when the patient may be emotionally disturbed. The physician has the privilege of nondisclosure but the decision must be based on sound medical judgment that disclosure of the risk would present a threat to the patient's well-being. The court rejects as a "paternalistic notion" the view that nondisclosure is justified where the physician believes that disclosure of the risk would discourage the patient from undergoing treatment which the physician considers necessary for the patient.

5) How is the issue of a casual connection between the physician's failure to disclose and damage or harm to the patient presented to the jury? If an undisclosed risk does not materialize, even if there was a duty to disclose, the omission is not actionable at law, since one of the basic elements of a malpractice action is harm to the patient. A more complicated issue is how causality is determined. "A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it."[11] A determination based on what was actually in the mind of the patient would make the decision depend on the credibility of the patient. A more adequate criterion is "what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance."[12] The patient's testimony may be persuasive but it is not to dominate the finding.

6) Must the plaintiff submit expert testimony in order to make a case that a physician has failed to disclose significant risks resulting from medical treatment? Where the patient claims that there was inade-

quate disclosure of risks to him and he is able to make out a prima facie case of nondisclosure the burden is then shifted to the physician, who must justify a privilege not to disclose. The court agrees that this is fair because the evidence justifying the privilege would be in the physician's possession. The burden of proof should be upon the person seeking an exception from the general rule of disclosure.

While expert testimony is necessary in many malpractice cases dealing with the risks of therapy, the court finds that on the issue of cause of injury and disability as discussed in this case most of the questions are answerable within ordinary human experience. "Lay witness testimony can completely establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment."[13]

Comment

The majority ruling, which bases the duty of the physician to disclose on medical custom, may be considered unfair to the patient. At the same time, the rule in *Canterbury* v. *Spence* that holds the physician to a duty to disclose the information material to a determination by the patient as to whether to undergo a treatment has been described as imposing an uncertain and unclear burden on the physician.

A recent law note in *New York University Law Review*,[14] while agreeing with the minority ruling, suggests that the uncertainty of this rule as it applies to physicians might be diminished by the adoption of the approach taken by the Food and Drug Administration (FDA) regulations on patient consent for the use of new drugs.[15] The regulation spells out the broad topics about which information would be provided; on the basis of this enumeration of topics the physician would then be required to furnish material information to the patient. Spelling out the physician's duty in some detail should reduce the uncertainty about standards of disclosure which is a cause of insecurity for the physician. At the same time the patient would be given greater understanding of the treatment proposed.

It is therefore suggested that the topics discussed by a physician with his patient should include items from the FDA regulations, together with a reference to the diagnosis and prognosis. Thus the physician would describe for the patient or his family "the diagnosis; the treatment's nature, expected duration and purpose; the method and means by

which the treatment is to be administered; the risks and hazards involved, including temporary and permanent after and side-effects; any alternative forms of therapy; expected beneficial effects of the treatment; and the prognosis if the patient foregoes treatment."[16]

Summary

This note has discussed a decision in a case where the physician failed to disclose to the patient a 1% possibility of paralysis resulting from laminectomy. This peril was deemed large enough to bring a duty of disclosure into play. An examination of the issue underlying the physician's duty to disclose risk and therapeutic alternatives has been presented. The court held that the duty to disclose does not spring from customs of medical practice nor does it require expert testimony. The decision requires the physician to disclose to the patient risks material to a determination as to whether to undergo the recommended treatment.

The patient's right of decision about his own body presents the physician with a duty of disclosure of risks incidental to treatment which, if they materialize, shift the burden to the physician to justify a policy of nondisclosure. By spelling out the topics on which the physician must disclose material information, the uncertainty about what is necessary disclosure may be diminished.

REFERENCES

1. 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064, 1972.
2. Idem., p. 776.
3. Idem., p. 778.
4. Idem., p. 779.
5. *Schloendorff* v. *Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93, 1914.
6. 344 N.Y.S. 2d 552 (App. Div., 4th Dept.), 1973.
7. Idem., p. 559.
8. Plante, M. L.: An analysis of "informed consent." *Fordham Law Rev. 36*:639-72, 1968.
9. Op. cit., ref. 1, p. 784.
10. Waltz, J. R. and Scheuneman, J. W.: Informed consent to therapy. *Northwestern U. Law Rev. 64*:628-50, 1970.
11. Op. cit., ref. 1, p. 790.
12. Idem., p. 791.
13. Idem., p. 792.
14. Informed consent—A proposed standard for medical disclosure. *N.Y.U. Law Rev. 48*:548, 1973.
15. FDA Regulations, Section 130.37, 21 C.F.R. 130.37, 1972.
16. Op. cit., ref. 14, p. 559.